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EXPERIENCE TO DATE OF IMPLEMENTING THE BAMAKO INITIATIVE: A REVIEW AND FIVE COUNTRY CASE-STUDIES*

Executive summary

SUMMARY

The present report contains the executive summary of the evaluation of the Bamako Initiative which was sponsored by the Overseas Development Administration (United Kingdom of Great Britain and Northern Ireland), the Danish International Development Agency, the Norwegian Agency for International Development and the Swedish International Development Authority. The evaluation, originally proposed by the United Kingdom at the 1990 session of the Executive Board, was carried out by the London School of Hygiene and Tropical Medicine. The School's Health Economies and Financing Programme, which conducted the evaluation, found that because it was too early for a formal evaluation of the Bamako Initiative, it would be better to conduct a review of the Initiative based on case-studies of five countries (Burundi, Guinea, Kenya, Nigeria and Uganda).

In addition to specific recommendations for each country, the review made 16 recommendations highlighting areas requiring improvement, including quality, affordability, pricing structures and payment mechanisms, cost recovery and the role of communities in the Initiative. The review also made two general recommendations concerning the need for support for the Initiative as an appropriate path towards the development of primary health care.

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The report also contains, as an annex, a note by the Executive Director in which he welcomes and endorses the findings of the review and stresses that continued and strengthened donor support is required if the Bamako Initiative is to fulfil its potential.

The complete review, in English, is available upon request from the UNICEF secretariat for study and reference.

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INTRODUCTION

1. The 1980s saw the development of severe problems in financing health services in sub-Saharan Africa. In many countries, health budgets declined in real terms in response to severe international recession and structural adjustment programmes. At the same time, demands on the health services increased owing to high population growth rates, successful social mobilization and the acquired immune deficiency syndrome (AIDS) pandemic.

2. In some countries, the implications of this crisis for the health services infrastructure have been all too clear, with health workers failing to receive salaries, drug supplies absent for substantial periods and long lists of equipment and vehicles awaiting repair.

3. In response to this situation, the Bamako Initiative was announced at a meeting of African Ministers of Health sponsored by the World Health Organization (WHO) and UNICEF in September 1987. The Initiative aimed to mobilize resources in order to increase the quality of health services using community financing and participation. At the 1990 session of the UNICEF Executive Board, it was proposed by the Overseas Development Administration (ODA) (United Kingdom) and agreed that an external evaluation of the Bamako Initiative should be carried out. The Health Economics and Financing Programme of the London School of Hygiene and Tropical Medicine undertook the evaluation.

4. Two hypotheses had originally been given in the terms of reference to guide the evaluation. These have been slightly amended and expressed as three separate hypotheses for clarity:

(a) The Bamako Initiative will improve the quality and appropriateness of health care provided to the majority of the population;

(b) The main mechanism for this improvement will be community involvement in the management and financing of local services;

(c) The Bamako Initiative will reduce the health expenditures of households by encouraging a switch to cheaper and more appropriate health service use.

5. At an early stage of the study it was agreed that it was still too early for a formal evaluation and the hypotheses given would be difficult to prove or disprove. The present paper, therefore, aims to come to preliminary conclusions as to the appropriateness and likely effectiveness of the Initiative in achieving these objectives.

6. The first stage of the evaluation was the completion of a policy review based on published literature and other documents. Five countries (Burundi, Guinea, Kenya, Nigeria and Uganda) were then selected as case-studies for the evaluation. The methodology for the case-studies consisted of national and subnational level interviews and document review, interviews and record review

at the health facility level, patient exit polls at health facilities, focus group discussions with community members and small household surveys.

I. WHAT IS THE BAMAKO INITIATIVE?

7. The policy review argued that the question of the definition of the Initiative was central to the debate regarding its appropriateness. Critics had defined the Initiative rather narrowly as a version of a revolving drug fund. Advocates had put forward a broader conception based on "revitalizing" the whole health infrastructure. A review of policy documentation suggested that the Initiative had always had an ambitious agenda, incorporating more than the elements of a revolving drug fund, but that articulation of key components in the process of health infrastructure development had evolved since the launch of the Initiative.

8. The five countries included in the evaluation were selected deliberately on the basis that specific differences in the components and organization of the Initiative would be covered. Nevertheless, it proved possible to identify common components of the Initiative and a set of "minimum criteria" which it was considered should guide the definition of future programmes.

9. It would seem that the Bamako Initiative in any country is likely to encompass community financing. This implies the use of revenues raised to improve the quality and coverage of services and, therefore, a general concern for quality with the Initiative. It is also likely to encompass community health development committees and a national involvement which aims to coordinate the communities and local government bodies involved and to integrate these activities into national health policies.

10. These common components might be considered the features of the Bamako Initiative and they may further be considered among the set of minimum conditions.

11. The features must be part of a programme with the objectives of improvements in quality and access, thereby corresponding with the overall objectives of the Initiative. Management and accountability are likely to be essential elements in the process of implementation of the Initiative if its objectives are to be achieved. Therefore, these strategic elements of management and accountability may also be considered among the minimum conditions for the Initiative.

12. The following set of minimum conditions can, therefore, be defined:

FEATURES	AIMS	STRATEGIC ELEMENTS
Community financing	Quality improvements	Management
Community participation	Greater accessibility	Accountability
National scope		

13. An addition to this list might be considered to be the need for formal identification with the Bamako Initiative. This is unimportant from the perspective of programme content and the assessment of its effectiveness in achieving the objectives of the Initiative. However, it is likely to be important in considerations of the policy process and the political dimensions of the Initiative.

14. The guiding principles as set out in the documentation of the Initiative describe desirable environmental characteristics for the Initiative. They are all sometimes present and sometimes absent in the case-study countries.

II. THE POLICY PROCESS

15. The announcement of the Initiative was endorsed jointly by UNICEF and the WHO Regional Office for Africa. The background to the thinking behind the Initiative, the origins of the idea and the process by which ministers and international organizations agreed to endorse it, is not documented. UNICEF emphasizes their role as facilitators of the ideas emanating from African countries, rather than as policy makers. It is difficult to draw a clear-cut distinction between the facilitation and initiation of ideas. This distinction is even more difficult where financial control rests with the "facilitating" organization. For this reason, the Initiative has repeatedly been seen as the "UNICEF Bamako Initiative", given the limited resources available to WHO.

16. It appears that adoption of the Initiative did not automatically signal the need for new activities with countries. In most countries, it is clear that UNICEF has played a dominant role and that WHO has not been centrally involved. National Governments have collaborated in what has been a UNICEF-led and driven activity.

17. In Uganda, the failure formally to adopt the Initiative appears to have arisen from the UNICEF country office's perceptions that this would conflict with the decentralization policy by ceding policy-making and control to New York. In addition, the Initiative was perceived to imply a model of pilot projects followed by larger-scale implementation, which was rejected. This case-study emphasizes the central role of UNICEF country offices in addition to what may have been popular conceptions about the nature of the Initiative at the time such decisions were being made. The Uganda country office may have had more scope for independent decision-making given the abundance of health sector donors in the country.

18. At the subnational level, the level of involvement of intermediate and local level authorities in the implementation of Initiative activities depends on existing government structures and particularly the nature and extent of decentralization. However, the major prerequisite for successful decentralization is the strengthening of capacity at lower levels. Without this, decentralization is unlikely to be successful and, therefore, decentralization is not in itself a guarantee of success.

III. QUALITY

19. It is clear that perceived quality of service is one of the most important determinants of a patient's choice of provider and willingness to pay. In particular, the role of deficient drug supply in deterring utilization has frequently been emphasized.

20. Some households' demands, such as overemphasis on drug supply, are deemed "inappropriate" by professionals. This raises issues of the extent to which policies should be guided by demand or professionally determined need. The Bamako Initiative has been much criticized for an overemphasis on drug supply by those who prefer a need-determined basis for policy-making.

21. The household survey protocol used in the case-studies included a number of questions relating to the household's perception of quality. In most of the surveys, over 80 per cent of respondents considered the government facilities to be good or very good. Focus group discussions tended to highlight drug shortages as the major shortfall in the quality of government facilities, but otherwise produced more mixed evidence. In general, exit polls suggested that users of health facilities were happy with the services they had received and that drug availability was often better than the focus groups had suggested.

22. It was difficult to determine whether quality perceptions, and particularly the perceptions of the trends in quality, were related to Bamako Initiative activities. Only in Guinea could the team be quite clear that improvements had resulted from the introduction of the programme since it had formed the basis for the redevelopment of health services following almost total collapse. In Nigeria, the team concluded that perceived improvements in drug availability were associated with the introduction of the revolving drug fund in 1985, if not the formal introduction of the Bamako Initiative in 1989. In other countries, the evidence was mixed and the early stage of programme review precluded firm conclusions.

23. The direct measurement of professionally determined quality was not attempted in most of the case-studies. Of the countries visited, only Guinea has institutionalized the use of "coverage curves" as an instrument for monitoring and evaluation. Using a combination of routinely available data and information collected during supervisory visits, a set of curves is constructed that uses indicators to measure progressively the availability, accessibility, acceptability, adequate coverage and effective coverage of primary curative care, immunization and antenatal care. Qualitative information is introduced through the "effective coverage" indicators, which include measures such as the correct following of standard protocols.

24. Results from an internal evaluation of the Guinea programme conducted in December 1990 suggest gradual improvement in average coverage levels for immunization. Adequate and effective coverage are still fairly low for both immunization and antenatal care, however. An important difficulty in interpreting the data, however, is that the Directeurs Prefectoral de la Santé

(Prefectoral Health Directors) are evaluated at least in part using the performance indicators from health centres they have evaluated themselves.

25. In other countries, less information related to quality is routinely collected. Some crude analyses of quality were undertaken in Burundi and Kenya which suggested that substantial quality problems exist.

26. The protocols focused on the community's perception of quality. A danger of reliance on this is that community financing may introduce incentives to meet community-defined quality standards at the expense of professional ones. Problems were highlighted with regard to professionally determined quality and in some countries problems of polypharmacy may be exacerbated by incentive structures that encourage a maximization of drug sales. However, an alternative possibility is that the Bamako Initiative could serve to lend greater support and credibility to services which have a low value as perceived by the community (such as some preventive activities) by linking them with valued and community-financed services.

IV. AFFORDABILITY

27. Evidence of existing payments and patterns of expenditure have often been cited as evidence of affordability of user charges. Affordability has also been addressed through direct questioning of users of services who may cite financial reasons as deterring utilization or comment on how affordable they consider a set of prices.

28. While utilization and demand data are clearly important and relevant, they are confused by availability of substitutes and quality perceptions. In addition, they ignore the implications of expenditure decisions for the rest of the household budget. A more acceptable definition of affordability may require that the long-term wealth situation of a household is not undermined. These considerations point towards a need-based concept of affordability rather than one of demand.

29. All these approaches can be considered to be addressing the question of absolute affordability. In some cases, it may be sufficient to demonstrate that a community-financed service makes services available more cheaply than they were before, or that household health expenditures are reduced in response to the new service. This implies a concept of relative affordability.

30. In general, communities did not raise problems of affordability of Bamako Initiative activities in focus group discussions, although many problems of affordability relating to higher-level services were cited. Household surveys provided mixed evidence on this question. The highest indications of inability to pay were in answer to the more general questions, such as "Do you usually have cash available to pay for health services?". More specific questions, where respondents were asked to remember an actual experience (for example, "Has cost ever prevented you from using health services?"), tended to elicit fewer positive responses.

31. If it is assumed that the more specific questions are the more reliable, the affordability problem might be restricted to be between 10 and 30 per cent of the population in most settings. In some villages, more extreme problems were evidenced, with almost complete non-utilization owing to cost or geographical access factors.

32. Not all respondents appeared to understand the concept of seasonality as opposed to monthly or weekly patterns in availability of cash, or general variability. Nevertheless, the position of seasonality of income produced uniformly high responses, which suggests that the design of all financing mechanisms should incorporate this consideration.

33. Borrowing from friends and relatives was the most common non-routine source of cash in all the countries included in the evaluation. It was of relatively small amounts paid back within a short period (usually one or two months).

34. The exit polls in general highlighted few problems of affordability. Most respondents said they had not had problems finding even the relatively high amounts charged by the mission facility in Uganda. These responses were significantly biased by the selection only of users, however.

35. In Kenya and Uganda, the charges for health services were compared with estimates of income and cash availability. Even those charges at the lowest level of services, which may appear to be minimal, are far from trivial when this comparison is made. Charges for higher-level services appear to reach prohibitive levels.

36. Overall, the evidence suggests a mixed picture of absolute affordability, but in three of the countries, improvements were noted in relative affordability. However, this need be no more than a marginal improvement and was not experienced by those who remained without access for geographical or economic reasons.

V. PRICING STRUCTURES AND PAYMENT MECHANISMS

37. Alternative pricing structures have implications for cost recovery, efficiency, equity and administrative costs.

38. Full marginal cost pricing is usually considered to be most efficient. However, in the health sector this ignores the multiple reasons for market imperfection, not least of which is the patient's knowledge of the value of possible treatments. Nevertheless, the impact of alternative pricing structures on incentives for overutilization (and underutilization) may be important. Although prepayment is unlikely to involve a progressive payment system, it is the only option that can share the costs of health care provision between the sick and the healthy. The danger of prepayment is that it may encourage overuse of health services (moral hazard) or the opting out of the system by those with the lowest health risks (adverse selection).

39. Despite the theoretical attractiveness on equity and access grounds of the prepayment system, in Burundi, poor families use this system less, suggesting the lump sum one-time payments are not perceived as worthwhile, given the uncertainty of future service need and availability. Although there is no evidence of moral hazard, there is some evidence of adverse selection in this system.

40. "Simple pricing" (the payment of a fixed rate rather than a scale of rates, which is termed "complex pricing") spreads the cost of health services more evenly among the sick and may reduce administrative costs. At the same time, it is likely to cause some unpredictability with regard to cost-recovery objectives, at least at first, since it requires an estimate of average cost that might not be accurate. However, complex pricing makes it more difficult for patients to know what they should be charged.

41. A further important aspect of the pricing structure is the way in which it integrates or fails to integrate the community-financed services with the rest of the national health services. In particular, pricing structures can reinforce or undermine the referral system. This was clearly a problem in both Kenya and Uganda, where free health centres (in Kenya) and hospital services (in both) created incentives for people to bypass the lower-level services at which there were charges.

42. Exemptions are fundamental to the balance between cost-recovery levels and affordability. They are often seen as the solution to the affordability problem for the poorest section of the population. However, in addition to revenue loss problems, exemptions may also lead to abuse of the system by those who face the least problems of ability to pay. Exemption mechanisms in the case-study countries generally have a very limited scope (as in Nigeria, Burundi and Kenya), appear ineffective in practice (Uganda) or do not exist (Guinea). In general, communities (at least to the extent that they are represented by their committees and the focus group discussions) appear to prefer to rely on the traditional mechanism of the extended family structure to support those with difficulties in paying.

43. There has been widespread concern that cost-recovery systems based on drug sales may create incentives for over-prescription and inappropriate use of drugs. The persistence of polypharmacy in Nigeria, where charges are based on the drugs prescribed, and of multiple diagnoses in Guinea, where the system of cost recovery is based on diagnosis, demonstrate that these fears are not without grounds. This perverse incentive (from an appropriate health care point of view) may be mitigated, but probably not altogether eliminated, through the use of standard treatment protocols and careful supervision.

44. As well as negative incentives, a pricing structure can be designed in order to encourage the use of certain items or services, in particular those that are most cost-effective. This may not always accord with the community's priorities, however. Profitability may be a more easily comprehensible goal.

VI. COST RECOVERY

45. Many community-financed services have demonstrated the capacity to generate large amounts of revenue. Nevertheless, the extent to which full cost recovery is possible depends on the capacity of the local market. If cost recovery cannot be achieved within a pricing structure (price levels and exemptions) that is affordable to the whole community, there is likely to be a trade-off between the degree of cost recovery and the economic accessibility of the community-financed service. In some situations, continued reliance on external (government and donor) funds is fundamental to the design of the community financing structure and is feasible. In these circumstances, it may have substantial advantages.

46. The five case-study countries realize very different levels of cost recovery, which reflect programme design rather than relative success. For example, in Guinea and Nigeria, the programmes have been designed to cover and achieve major elements of recurrent cost. In Burundi and Uganda, this had not been the objective.

47. At present, the convertibility of local into foreign currency does not present problems, as UNICEF guarantees the transaction in most of the countries. In the context of significant pressure for exchange liberalization, it is possible that difficulties in converting foreign currency for any purpose will diminish steadily. The prospect of frequent currency devaluation does raise other issues of the capacity of communities to raise the real international costs of drugs compared with the effectively subsidized costs expressed in an overvalued local currency. Local production of drugs may help to stem drug price inflation, but may also present problems of quality control and efficiency of production.

48. In all of the countries, the Initiative has incurred substantial development costs which have been borne by donors. In addition, pilot projects receive a great deal of external support in such intangible forms as international interest and visitors from the national capital and overseas, which can be important in motivating those involved from national to community levels. As programmes move beyond the pilot project stage, it is possible that the importance of these inputs will become clear if new projects fail to register similar levels of achievement.

49. Recognition of the high external costs of the activities prompts queries about the cost-effectiveness of the programme. It is difficult to comment in detail about this since a number of different sources of external funds have frequently been involved, and government costs cannot be calculated without a detailed study. Nevertheless, external costs predicted by UNICEF for the period 1991-1995 produce estimates of cost per person theoretically covered ranging from $1.83 (Guinea) to $0.44 (Kenya). These do not appear excessive, but may still not be easily obtainable by countries that have not yet embarked on the process.

50. Only Guinea has seriously considered developing a policy to redistribute resources from those facilities that can more easily raise revenues to those that have greater difficulty. Such a policy presents many problems, which probably explains the lack of consideration in other countries.

VII. COMMUNITY PARTICIPATION

51. Community participation is central to the Bamako Initiative, but it is surprisingly ill-defined and vague in policy documents, as well as in country reports and evaluations. Whether community participation will really provide the vehicle for encouraging and assisting communities to become involved in decision-making relating to their own health, or be limited to generating resources (i.e., paying fees), is a key issue.

52. Documentation of the Initiative suggests that communities are expected to fulfil a vast array of functions that require varying levels of technical ability. The diversity of these elements, and the level of technical expertise that may be required for substantive participation, may restrict the level of meaningful involvement by the community. Perhaps most significantly, the community link most clearly specified in the documentation of the Initiative is with funds.

53. Despite the considerable concern that has been expressed regarding the management of community-generated funds, in many respects committees in the case-study countries were coping well with their management role. Most of the communities and committees were making sensible decisions about the use of revenues, even where the decisions to be made were very difficult. Some tasks, such as record-keeping and controlling abuse of drug supplies, were carried out less effectively, however. A feature observed in some countries was that the committees' role in transmitting information from the health centres to the population was more important than in communicating information in the opposite direction.

54. Failure on the part of communities to achieve managerial objectives is often blamed on the capacity of communities to perform the functions allocated to them. This is only one of a number of possible explanations. Support from higher levels of the health system and effective role definition are also potentially important. Nevertheless, the communities appeared enthusiastic and supportive of the Initiative in all countries, which is an important vote of confidence from its clients.

55. Overall, the impression of the country study teams was that the representativeness of the community health committees is doubtful, either because of the process of selection or because of the large number of people they are supposed to represent. Problems included the lack of awareness of the committees' existence, the requirement for literacy among at least some members and limited participation by women.

56. The reimbursement of community health workers has long been recognized as a key problem in primary health care (PHC). While many communities have proved willing to contribute in a small way and usually in kind, such support has often not been sufficient to affect the attrition rate significantly. In any case, this was not considered to be a useful solution by any of the committee and community members with whom it was discussed in focus group discussions considered this a useful solution. Community financing presents a potential source of more significant reimbursement of health workers. However, it is important to ensure that incentives created by a reimbursement system that depends on sales levels do not prompt health workers to prescribe unnecessary treatments.

57. Overall, community participation is an essential element of the Bamako Initiative and of community financing in general. Despite universal community support and enthusiasm in the five countries, the case-studies identify mixed success with other aspects of the community's role and a number of dilemmas lacking solutions.

VIII. CONCLUSIONS

58. Blanket statements about the success or otherwise of a programme that has taken such a wide range of forms in very different contexts are not likely to be warranted. In addition, it has already been emphasized that most of the case-studies reviewed activities in very early stages and it would not be fair to form a final judgement on the basis of their achievements to date.

59. Some environmental characteristics of the case-study countries seem to have been particularly important in having determined the form in which the Initiative was introduced. In turn, these characteristics are also likely to have been instrumental in affecting the success with which the Initiative has been implemented in particular respects.

60. First, a major distinction has to be drawn between those countries such as Kenya and Uganda (and, less clearly, Nigeria) that are introducing charges in the context of a tradition of free services, and those such as Guinea and Burundi where the Initiative involves some degree of reorientation of existing charges.

61. Secondly, the adequacy of resource availability to existing health services prior to the implementation of the Initiative may be an important criterion in determining whether the Initiative is aimed primarily at strengthening existing services or at expanding coverage to unserved populations. This is also likely to be important in the evaluation of the programme's success, particularly where this is measured in relative terms.

62. Thirdly, in all of the countries the Initiative relies on a certain degree of decentralization of management and administration. In countries in which these functions are already substantially decentralized, and particularly where the Initiative involves efforts to strengthen capacity at peripheral levels, implementation may pose fewer problems.

63. Finally, the success of the Initiative is affected by the extent to which it has to compete with other goods and services. This includes the extent of private drug marketing and "competing" alternative government services.

64. In addition to identifying these important general characteristics, each case-study drew a number of conclusions and recommendations about the activities reviewed. While these are clearly not generalizable, they may be of considerable interest and educative value for those countries considering embarking on the Initiative in designing a programme and avoiding the most likely setbacks.

65. Guinea has the most developed and most clearly successful programme. The team concluded that there had been "dramatic improvement in the accessibility, utilization and coverage of basic health services". Nevertheless, there were serious questions about the sustainability of the activities in Guinea and their replicability elsewhere, given the substantial external funds that have been received. In addition, some problems of affordability were identified and it was thought that further difficulties were likely to be experienced in the process of decentralization. Management and monitoring were probably at their most advanced in Guinea, but it was still considered possible to identify ways in which they might be improved.

66. In Kenya, the clearest successes of the Initiative were its generation of substantial community enthusiasm and a demonstrated willingness and ability to pay community pharmacy prices. The Initiative appeared to improve the relative affordability of the most basic health services. Affordability problems at higher levels (from the dispensary level upwards) were not affected, however. The most important problems arose in the areas of logistics, management, monitoring and supervision. Clear strategies for these had not been developed in the design of the Initiative.

67. In Nigeria, there was evidence of improved utilization, drug availability and relative affordability as a result of the implementation of revolving drug funds, which had been initiated before the formal arrival of the Bamako Initiative but then integrated into it. However, there were clear differences in affordability and patient perceptions of the activities included in the Initiative between the two areas visited and some absolute affordability problems were identified.

68. In Burundi, the Initiative was at a very early stage of development and its design differed from the Initiative in the other case-studies in the important respect that it does not yet include a community-financing component. It was considered too early to evaluate whether any improvement in quality had taken place as a result of the implementation of the Initiative. A review of the prepayment system, although not formally part of the Initiative, assessed its potential to be incorporated and adapted to a system of community financing. Utilization of the system was adversely affected by community perceptions of drug shortages and there was evidence of adverse selection. Affordability problems were indicated such that the poorest families appeared to choose the fee-for-service system despite being aware that the ultimate total charge was likely to be higher.

69. Finally, in Uganda, it was concluded that the activities studied qualified as Bamako Initiative activities even though they are not formally part of it. Uganda faces some of the most difficult and entrenched problems of health service provision of all the countries reviewed. In particular, a large unregulated private drug market and very poorly paid and motivated health workers undermine efforts to improve service provision. In this light it may be more significant that one district showed signs of making considerable headway in health service provision using health management committees and a user charge policy, than that there was a lack of such evidence in the other three districts visited.

70. It appears that it is possible in most contexts to raise amounts of revenue capable of covering significant components of recurrent costs through community financing and to improve the relative affordability of health services for the communities affected. Relative affordability was considered to have improved in three of the five countries. It should be emphasized that a necessary condition for relative affordability improvements is the retention of revenue. Improvement requires that services must substitute for more expensive ones used previously. This can only result from direct coverage improvements, or from quality improvements that are sufficient to induce the population to switch their utilization even in the presence of new charges.

71. In all countries, however, problems of absolute affordability remained. Marginalized groups remain without access to health services for a variety of reasons. In no case did this study uncover evidence that the situation of these groups had actually worsened as a result of the Initiative. Nevertheless, it is too early to conclude firmly on this point, and there is a clear need to continue to consider ways of improving their access and to monitor their situation. Although current exemption mechanisms seem to work poorly and sometimes even detrimentally in practice, the search for effective mechanisms should not be abandoned. Innovative methods of addressing this problem may ultimately go beyond notions of exemption, perhaps, for example, addressing community support mechanisms more generally.

72. Community health committees were to varying degrees representative; in no case did they allocate an equal role to women and in some cases they performed the function only of a one-way channel of information from the health facilities to the communities. It is likely that almost any evaluation of community participation in almost any context would reach similar conclusions. However, there is a need to define community participation conceptually as it is expected within the Initiative and to identify what can realistically be achieved and what the Initiative requires to ensure its viability. The setting up of committees cannot be considered an adequate conceptual definition.

73. Finally, it is clear that problems in the area of quality are widespread in all the services that are included in the Initiative. This is similarly unsurprising and serves to emphasize the importance of the stress on quality that already exists. Although improvements in drug supply may be relatively easy to achieve, improvements in adherence to standard diagnosis, treatment

and prescription protocols are more difficult and involve higher levels of management, monitoring and supervision for which there are no clear community-financing principles. In addition, this support is required in order to ensure that existing quality is not undermined by incentives that may exist within the pricing structures that have been introduced. Monitoring and supervision examples from Guinea may be the most important aspects of the Bamako Initiative "model" to export.

74. The evaluation team's overall conclusion on the activities they have studied is that there is much that looks promising. The development of PHC according to the "features", "aims" and "strategic elements", which have been used here to define the minimum criteria of the Bamako Initiative, alongside the eight guiding principles, appeared to the team to be an appropriate course of action for the future.

IX. RECOMMENDATIONS

75. The following recommendations are confined to those of general relevance (specific recommendations concerning particular country programmes can be found in individual country reports). They focus particularly on areas where further work is needed to understand better the implications of the activities reviewed:

(a) General:

(i) The strategy of "revitalizing health services" as defined by the "features" of community financing, community participation and national orientation; "aims" of improving quality and extending access; and "strategic elements" of management and accountability, together with the eight guiding principles of the Bamako Initiative, should be supported as an appropriate path towards the development of PHC. Piecemeal and unbalanced approaches that omit some of these elements are inadequate;

(ii) UNICEF and other agencies should continue to support countries' efforts to implement the Bamako Initiative and the need for substantial investment in this process should be recognized;

(b) Quality:

(i) Continued attention needs to be directed at ways of improving the quality of services delivered at peripheral levels;

(ii) The strengthening of management capacity at peripheral level should be considered a priority to ensure adequate district and health facility monitoring and supervision with the objective of increasing the quality of Bamako Initiative activities;

(iii) In some countries, the systems of monitoring and supervision used in Guinea may provide suitable models;

(iv) Consideration of how to finance monitoring and supervision structures that extend to the most peripheral levels are appropriately a concern of the Bamako Initiative;

(c) Affordability:

(i) More research is needed to identify which groups remain without access to health services and how this problem can best be addressed. Options may include ways of operating exemption policies and sliding scales so that they are targeted effectively, and interventions focused on strengthening traditional support mechanisms;

(ii) Issues of affordability and access should continue to be stressed in Bamako Initiative documentation and in programme design;

(d) Pricing structures and payment mechanisms:

(i) Bamako Initiative programmes should continue to emphasize the retention of revenues raised through community financing within health services and at local level. Improvements in even relative affordability cannot be achieved without this feature;

(ii) The Bamako Initiative should be integrated into a comprehensive health financing policy that also addresses problems of affordability at secondary and higher levels of the referral system;

(iii) Concern for revenue generation should be balanced by concern that pricing and payment mechanisms should not encourage excessive drug use or other undesirable practices,

(e) Cost recovery: Establishment of national drug policies aimed at ensuring the supply of essential drugs at minimum prices is essential if sustainability is to be achieved;

(f) The role of communities in the Initiative:

(i) More research is needed into ways in which communities can participate most effectively to achieve the objectives of the Bamako Initiative in each country;

(ii) The objectives of community participation in the Bamako Initiative need to be clarified at international level and specified within countries. This should include the design of clear guidelines as to what is expected of communities;

(iii) Linkages between the community's committees and the rest of the health system need to be clear and supportive;

(iv) National policy makers should emphasize the need for the involvement of women in community committees and identify ways to encourage this.

Annex

INFORMATION NOTE BY THE EXECUTIVE DIRECTOR

Background

1. The Bamako Initiative was launched in September 1987 at a regional meeting of African Ministers of Health in order to revitalize health care systems in sub-Saharan Africa, which had developed severe problems, particularly because of the unprecedented and prolonged international recession and the effect of structural adjustment programmes. The Initiative aims to provide accessible, affordable and sustainable health care delivery systems in sub-Saharan Africa with the involvement of communities in management and financing. The Bamako Initiative was endorsed by the Executive Board at its 1988 session (E/ICEF/1988/13, decision 1988/3).

2. In 1988, the Regional Office for Africa of the World Health Organization (WHO) and UNICEF adopted eight fundamental principles as operational guidelines for the Bamako Initiative:

(a) National commitment to accelerating the provision of universally accessible PHC services;

(b) Substantial decentralization to the district level of the health ministry's decision-making for the management of PHC;

(c) Decentralized management of community resources, thus allowing the funds collected at local facilities to remain under community control;

(d) The application of consistent principles governing community financing for health care services throughout the different levels of the health system, making it inappropriate to provide free service at urban hospitals while requiring payment for community-based services;

(e) Substantial government financial support for primary health care (PHC), to ensure that the health budget is maintained at least at its current level of support to district and local services;

(f) Essential drug policies that are compatible with, and complementary to, the rational development of PHC;

(g) Measures for ensuring that the poorest people have access to PHC services;

(h) The clear definition of intermediate health system and management objectives and the establishment of indicators to measure them.

3. The Bamako Initiative is now operational in 33 countries. While the Initiative's original eight principles have remained valid and have been adhered to, local variations have emerged that are unique to each country situation, and often even to each community situation. (See document E/ICEF/1992/L.6 for a report on the latest developments of the Initiative.)

4. During its 1990 session, the Executive Board welcomed the offer of the Overseas Development Administration (ODA) (United Kingdom) to finance an evaluation of the Bamako Initiative. The Danish International Development Agency, the Norwegian Agency for International Development and the Swedish International Development Authority also became sponsors of the evaluation.

5. The evaluation was carried out by the London School of Hygiene and Tropical Medicine. However, the team responsible for the evaluation decided that it was too soon for a formal evaluation and suggested instead a review based on the case-studies of five countries with the aim of drawing some preliminary conclusions regarding the appropriateness and likely effectiveness of the Initiative in achieving the following three objectives:

(a) Improvements in the quality and appropriateness of health care provided to the majority of the population;

(b) Community involvement in the management and financing of local services;

(c) Reduction of households' health expenditure by encouraging a switch to cheaper and more appropriate health service use.

6. Burundi, Guinea, Kenya, Nigeria and Uganda were chosen for case-studies. Although Uganda has not been designated as a Bamako Initiative country, it has carried out similar activities. The five country studies have shown the unique experience of each country in organizing government health service structures and in the concomitant development of community structures. They have provided a better understanding of the Initiative's process, outcome to date and emerging issues and problems.

Principal findings

7. The Executive Director welcomes and endorses the 16 recommendations of the review and concurs with the general recommendations that:

(a) The strategy of revitalizing health services as defined by the features of community financing, community participation and national orientation, the aims of improving quality and extending access and the strategic elements of management and accountability, together with the Initiative's eight guiding principles, should be supported as an appropriate path towards the development of PHC. Piecemeal and unbalanced approaches that omit some of these elements are inadequate;

(b) UNICEF and other agencies should continue to support countries' efforts to implement the Bamako Initiative and the need for substantial investment in this process should be recognized.

8. The review also made 14 other useful and supportive recommendations on quality, affordability, pricing structures and payment mechanisms, cost recovery and the role of communities in the Initiative, which are discussed below. It is significant that the fundamental features of the Bamako Initiative as conceived at the time of its establishment were found to be preconditions for its success (appropriate decentralization, clear policy framework and appropriate coordination, local control and retention in the health systems of community funds, the adoption of essential drugs policies and the use of generic drugs).

9. The review also made specific recommendations regarding each country, which will be incorporated or borne in mind during the implementation of the Initiative in the countries concerned and in countries facing similar problems. In such an innovative initiative, "learning by doing" must be the norm for operations, while learning from successes and failures of other countries will be crucial.

Quality

10. The review stressed the importance of continued attention to the quality of service at peripheral levels and the need for adequate monitoring and supervision, citing the example of Guinea as a probable appropriate model. This factor cannot be overstressed, as experience had indicated that without adequate or improved quality of service, the communities are in fact unwilling to pay because of the consequent decline in the use of services.

Affordability

11. The issue of equity was raised by the review. The exemptions policy adopted has not always worked; equity has long been recognized as an issue of the programme's effectiveness, although admittedly there are no easy solutions as it is related not only to economic factors, but also to cultural values. Many societies are reluctant to delineate part of the population as poor or indigent and prefer to develop their own solutions. All financing options need to be explored. The Executive Director supports the recommendations that affordability and access continue to be stressed and that exemption policies and sliding payment scales might need to be looked into, together with traditional support structures. The issue has also been discussed at length in the progress report on the Bamako Initiative (E/ICEF/1992/L.6).

Pricing structures and payment mechanisms

12. It is interesting to note that the review has not found that excessive use of drugs is used to generate more revenue, although vigilance needs to be maintained against pricing and payment mechanisms that could encourage excessive drug use or other undesirable practices.

13. The review reaffirmed the importance of the retention of revenue raised through community financing within health services and at the local level. It is the fundamental principle of the Bamako Initiative that the funds raised by the communities not only be retained by, but also managed by communities. As pointed out in the review, improvements even in relative affordability cannot be achieved without this fundamental feature. Although it was one of the original aims of the Initiative, it has not been possible to address the problems of affordability at secondary and higher levels of the referral system, but the review has now drawn attention to the issue.

Cost recovery

14. The Executive Director concurs with the view expressed in the review that establishment of national drug policies aimed at ensuring the supply of essential drugs at minimum prices is essential if sustainability is to be achieved. UNICEF will need to continue to work with WHO, the World Bank and other partners to ensure that national drug policies based on essential drugs and the concept of the rational use of drugs are being adopted by all countries involved. The adoption of such policies would ensure more economical costs, while preventing overprescription and other forms of abuse and misuse through standard treatment schedules, improved supervision and accountability.

Role of communities

15. The review recommends more research into ways in which communities can participate most effectively, as well as further clarification of the objectives of their participation and various linkages that need to be developed. Experience indicates that the best system might be one with a judicious balance between "bottom-up" and "top-down" approaches so that communities could manage their own affairs with appropriate support and supervision from other echelons. However, it is imperative that communities be allowed to manage their own affairs and be the arbiters of their own fate, thus ensuring community ownership and interest, leading to sustainability of the programmes.

16. The Executive Director concurs with the recommendation that national policy makers should emphasize the need for the involvement of women in community committees and identify ways to encourage this involvement. The area has been deficient to date and a conscious effort is now called for.

Conclusion

17. The Executive Director has taken note of and supports all 16 recommendations made in the evaluation. The country-specific recommendations will be reviewed with national authorities and UNICEF will encourage other partners to join in this endeavour. The Bamako Initiative would benefit from financing, technical support and the sustained interest of its international and bilateral partners.

18. The Bamako Initiative will retain its comprehensive approach, but it will be adapted to the unique situation of each country and pay attention to establishing systems and evolving through the process of "learning by doing". Major challenges for the future include the problems of the marginalized poor and the exploration of different forms of payment and financing mechanisms to ensure equity, affordability and access. While a good beginning has been made, continued and strengthened donor support is required if the Initiative is to fulfil its potential, as endorsed by the review.

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Executive Board
Organizational session*
26 June 1992

PROVISIONAL AGENDA

1. Opening of the session.

2. Election of the Chairman of the Executive Board.

3. Election of the first, second, third and fourth Vice-Chairmen of the Executive Board.

4. Election of the Chairman and the Vice-Chairman of the Programme Committee.

5. Election of the Chairman and the Vice-Chairman of the Committee on Administration and Finance.

6. Election of the UNICEF representation on the UNICEF/WHO Joint Committee on Health Policy.

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* The June organizational session of the Executive Board, with its composition as at 1 August 1992, is for the sole purpose of electing officers of the Board for the period 1 August 1992 to 31 July 1993 and of electing UNICEF representatives on the UNICEF/World Health Organization (WHO) Joint Committee on Health Policy (JCHP) - in even years - and on the United Nations Educational, Scientific and Cultural Organization (UNESCO)/UNICEF Joint Committee on Education (JCE) - in odd years. A background note for the session is contained in E/ICEF/1992/L.22, which also includes Executive Board membership as at 1 August 1992.

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